MNVP

Pre-Intake Information

713 S. Pear Orchard Road
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Sponsored and Supported by the Mississippi Board of Nursing

To All Potential Participants:

We are excited to have the opportunity to sit down with you and discuss your potential enrollment in MnVP.

Prior to coming to our office to meet with us, we would like to give you some basic information about the program and request the completion of some paperwork in order to decrease the amount of time spent on paperwork and increase the amount of time our staff can spend addressing questions/issues important to you during your visit.

MnVP was designed to assist nurses throughout the state with substance use and/or mental health issues by providing support while avoiding disciplinary actions (MS Admin Code Part 2826) . MnVP does this through a Monitoring Agreement.

This Monitoring Agreement is personalized for each participant but may include:

- Nursing practice restrictions including single state status
- Employment restrictions (including restrictions in environments that are unsupervised and/or hours worked)
- Agreement to participate in drug testing through Affinity (including $75 credit requirement upon signing up and payment for all testing costs)
- Participation in support groups (AA, NA, Celebrate Recovery, Recovery Support Group, etc.)
- Participation in clinical recommendations from an approved BON provider
- Limitations on medications (over the counter and prescribed)
- Completion of monthly/quarterly reports
- Return to work assessment
- Disclosure of participation in the program to employer

It is also important to note that all costs are covered by the participant in the program.

We look forward to discussing any questions you have about MnVP during your scheduled appointment.

Please complete the following forms and return to us at least 2 business days before your appointment.

Thank you,

Casey A. Loper, LMSW
MNVP Program Manager

MnVP Pre-Intake Information

Today's Date: _____

Personal Information:

Full Name: _____ Preferred Name: _____
Previous Name(s): _____
DOB: _____ SS#: _____ Contact #: _____
Phone Type: Cell Home Work
Home Address: _____
Mailing Address (if different): _____
Preferred Email Address: _____
Emergency Contact (Name and Phone #): _____

License Information:

Licensure Information/Certification: _____
Status of MS License (circle one): Active Lapsed Inactive Applicant Other
If other, please explain: _____
If ARPN, list all practice sites and collaborating physicians:_____

Employment Information:

Are you currently employed as a nurse?_____
If yes, please list: Employer/Practice Name: _____
Employer/Practice Address:_____
Employer/Practice Phone #: _____
Please list any other places currently employed (nursing or not): _____
_____Please list any employment terminations or disciplinary actions: _____
_____
_____

Treatment Information:

List all inpatient/outpatient A&D treatment, therapy, evaluation(s) and/or psychiatric treatment (Please indicate if it is past/current, list facility name, dates of service, diagnosis, duration of services and discharge status):
_____
_____
_____
_____
List all psychiatric diagnoses (mental/behavioral health and/or A&D):
_____
_____
List all substances abused (past and present):
_____
_____

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Health Care Provider Information:

Please include provider's name, agency name, city/state, and phone #

Primary Care Physician: _____

_____

Mental Health Prescriber:

_____

_____

Therapist:

_____

_____

Medical Information:

Current/chronic medical concerns:

_____

_____

_____

Current medications (list name and dosage):

_____

_____

_____

Legal Information:

Do you have any legal charges pending? (circle one): Yes - Misdemeanor Yes - Felony No

If yes, please explain (including the charge, jurisdiction, status, and next court date):

_____

_____

_____

Are you currently on any form of probation or parole? (circle one): Yes No

If yes, please explain: _____

_____

Please list any malpractice claims, including outcomes: _____

_____

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Please explain the circumstances that lead to an MnVP referral and why you want to be considered for the program:

Signature: _____ Date: _____

(Please note that your signature is a verification that all information is accurate and not an agreement to enroll in the program)

INTERNAL USE ONLY

Person Receiving Packet:_____

Date Received by MnVP:_____

Intake Date Scheduled:_____